



October 12, 2006

Linda Cole, Chief
LTC Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: State Health Plan for Facilities and Services: Nursing Homes, Home Health Agency, and Hospice Services, COMAR 10.24.08

Dear Ms. Cole,

The Health Facilities Association of Maryland (HFAM) appreciates the opportunity to submit comments on proposed changes to COMAR 10.24.08 State Health Plan ("SHP") for Facilities and Services: Nursing Homes, Home Health Agency, and Hospice Services (the "Chapter") that were released for informal public comment on September 12, 2006. Following are our recommendations for changes to the regulations, drawn from comments by a cross-section of our facility members. We urge the Maryland Health Care Commission ("MHCC") to seriously consider our concerns and recommendations and would be pleased to respond to any questions concerning these proposed changes.

Following are comments concerning the draft changes to the Chapter's pertaining to comprehensive care facilities ("CCFs").

Renovation and Replacement Projects

In several places, the Chapter comments on the aging nature of CCFs in Maryland. This points to the need to renovate and replace existing CCFs via a certificate of need ("CON"). Yet, the Chapter imposes far more restrictive policies on renovations and relocations of existing CCFs that will impede the ability of providers to improve and upgrade CCF services. As it stands now, the cost of construction runs much higher than our Medicaid reimbursement allowance for capital so it is going to be very difficult to make the replacement of a facility financially feasible with significantly higher construction standards. For example:

- Section .05A(3)(d), p.14: There is new language requiring an applicant for a renovation or replacement of an existing facility to "demonstrate that it has made significant progress in discharging nursing home residents to alternative community-based programs, consistent with the population services as demonstrated by: average length of stay, discharged by destination site, readmission rates and other data requested by the Commission." Thus, a facility that might in the future need to renovate or replace its building in a way that requires a CON would need to first discharge residents,

demonstrate that it has made progress in the particular ways cited, that the progress has been “significant,” and that it can supply whatever data the Commission might request. This would translate into a loss of residents and revenues needed to support its improved facility.

- Section .05A(5)(b), p. 15: This provision is unclear in that it requires a renovation CON to reduce the number of patient rooms where there are more than two residents per room or more than two residents share a toilet. Those upgrades are appropriate where a renovation will involve resident rooms and bathrooms. Sometimes, a renovation project may not involve those areas of the facility. The provision should make clear this does not apply when the renovations do not include patient rooms.
- Section .05A(7)(b) and (c), p. 15: Rather than reviewing applicant designs on their merits, the Chapter would introduce a new requirement that designs be based on “citations from the long term care literature.” Those citations, if used in the design development, should be disclosed but this requirement risks dissuading facilities from being innovative in their designs to meet their particular needs. Also, it is unclear what kind of a “plan for the evaluation of how the therapeutic milieu benefits resident outcomes” would satisfy the agency. The meaning and intent of this provision is unclear.
- Section .05B(1)(a) and (b), p. 16: To plan effectively for a major renovation or replacement of a CCF, providers must be able to rely on their historical financial performance and projections of performance based on available revenues. Above, there is a reference to a provision that suggests that in the period leading up to an application for a replacement or upgraded facility residents would need to be discharged to a greater degree. This provision suggests that even though the Commission’s inventory for CCF beds includes the beds in question, the “need” for them would need to be re-justified. This is different than other SHP chapters in which the SHP finds need and CONs are issued based on that finding of need. This new provision risks CCFs that are aging as the MHCC has already identified, not being replaced by new and innovative designs.
- Section .05C(1), p. 18: Sometimes facilities need the incremental revenue from waiver beds to sustain a highly beneficial renovation. This provision refers to beds based solely on the Commission’s inventory. A CCF may be entitled to waiver beds but for the lack of present space in an existing, outdated facility. This provision should enable an applicant for a renovation for a CON to include space that would be immediately be put into service using incremental waiver beds, as those revenues may make the difference between a viable or more innovative renovation or none at all.

CCF Bed Need

Under Policy 3.2 and in this section, references are made to the “needs of the jurisdiction,” “demographic needs,” and “utilization trends.” We ask that the Commission take into account the pending BRAC (Base Realignment and Closure) plans for Maryland when evaluating needs by jurisdiction. We anticipate that families relocating to Maryland may bring with them family members who require long-term care.

- Section .05B(1)(a), p. 16: In other Chapters, the MHCC has deviated from a formulaic approach to need. In this Chapter, it is maintained. Under the CON review criteria, where there is a formula in the SHP, it governs the review. Yet, even though the MHCC has a detailed bed need projection methodology that applies under Section .05A(1) and has identified several jurisdictions in which CCF beds are needed, the Chapter would impose under Section .05B(1)(a) yet stricter requirements for demonstrating need the agency has already determined exists.

Medicaid Memorandum of Understanding

The Chapter would maintain this requirement. However, it would adjust the formula by which the Medicaid percentage is calculated. Some observations are in order:

- HFAM already advocated before the Commission for a review of this requirement. The Chapter does not detail why it is necessary to continue this requirement. It is anomalous to have such a requirement that encourages higher lengths of stay for Medicaid beneficiaries, when there is a MHCC interest throughout the document to the discharge of residents to other settings.
- The MOUs signed historically by CCFs state that they terminate if the MHCC eliminates the requirement. Section .05A(2)(B), p. 13 alters the formula for new CON applicants in a helpful way, by including a 15.5 percent adjusting factor. If this MOU requirement is maintained, the MHCC should put affected CCFs with existing MOUs at parity by applying this reduction across the board.
- Section .05B(4)(e), p. 17: This new language would impose a new limitation on the grounds upon which a waiver from the requirement of an MOU would be granted. In addition to those stated, there may be particular financial or other requirements that support a waiver. The MHCC does not presently self-limit the reasons it will consider. Applicants should be permitted to make appropriate proposals for a waiver as has historically been the case.

Mergers and Consolidation

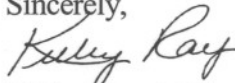
The Chapter would newly restrict the types of companies that would qualify for filings under the “merger and consolidation” rules, which enable companies to efficiently use their CCFs with MHCC review, but through a process other than the CON process. Section .16B(29), p. 69 would change the definition of a merger to exclude a reapportionment and reorganization of existing beds or services among health care facilities of an organization that controls the business and programmatic functions of more than one nursing home or more than entity one of which holds a nursing home CON. A justification for this definitional change has not been put forward. Companies that have been determined by the MHCC to qualify under the existing definition to be able to seek MHCC approval of mergers and consolidation among their facilities, should not suddenly be made subject to full CON review for realignments among their facilities, due to this definitional change.

Additional Comments

- Section .04B(1)(b)(ii), p. 11: Waiver beds will only available if there is existing "licensable" space in which they could be located. It should be clarified if this represents a change in policy that will restrict the availability of waiver beds in existing space.
- Section .05A(3)(c), p. 14: There is a new reference to facilities being required to provide access to the Department of Disabilities. An explanation of this new requirement and the types of existing residents affected should be offered.
- Section .05A(9), p. 16: This requires an applicant to enter into certain types of "partnership." A partnership is a legal term of art referring to equity participation in a particular form of entity such as a general partnership, a limited partnership or a limited liability partnership. We speculate that the MHCC is not requiring CCFs to enter into joint ventures or other forms of joint equity arrangements. If this term is being used in a colloquial or slang manner, a different term is advisable. The current Chapter refers to other types of agreements accomplishing the same objective. The intent of the new wording is unclear.
- There are a myriad of places where the MHCC adds the requirement of that an applicant "document" compliance with particular standards that have historically been in the current Chapter. Rather than making the CON application more brief and focused, these new requirements will significantly increase the size of the applications to be filed and make the review more, rather than less, detail oriented.

If you have any questions about these comments, please feel free to call me at 410.290.5132, ext. 102 or on my cell at 443.255.4034.

Sincerely,



Kelley Ray, M.S.

Vice President of Government Relations

cc Adele Wilzack R.N., M.S.
President